Do general practitioners and general psychiatrists want to look after drug misusers? Evaluation of a non-specialist treatment policy

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SUMMARY. A new means of monitoring drug misuse which was developed in the north west of England, but is now widely used throughout the United Kingdom, is described and evaluated. Report forms which had been specially designed and ensured the anonymity of drug misusers were widely distributed among doctors and non-medical health workers who may have had contact with drug misusers. The forms were returned post-free to a centre where they were entered on a customized drug misuse database. There were 2127 reports from the north west of England (population 3.99 million) relating to 1792 individuals over a 15-month period. However, despite intensive promotion of the project among doctors, the number of reports from doctors remained virtually unchanged over the 15 months despite a 33% increase in the overall number of reports. When the reports from three health districts, selected so as to be representative of the region demographically (total population 658 500, population aged 15–44 years 292 200), were considered there was a substantial fall (70%) in reports from general practitioners which was considerably greater than the 2% fall in all reports. In a linked study all the psychiatrists, 30% of probation officers and a one in six sample of general practitioners from the three selected health districts were approached for interview at the beginning of the 15-month period and again a year later. This structured enquiry about caseloads, treatment, and attitudes also revealed a fall in the number of drug misusers attended by general practitioners and general psychiatrists and a reduction in the services provided for them by general practitioners.

These findings raise doubts about the viability of national policies which expect unsupported general practitioners or general psychiatrists to be the first line of treatment for drug misusers.

Keywords: drug abuse; workload; health service delivery; GPs' role; doctors' attitude.

Introduction

THE role of general practitioners should be given serious consideration in the development of a strategy for responding to the current drugs problem for they stand in a vital strategic position as 'both provider and gatekeeper for key services in response to this problem.'[1] This is only one of several calls for general practitioners and general psychiatrists to be the main providers of care to the drug misuser.[2–4] Central government identifies general practitioners and general psychiatrists as two of the main avenues through which services must be delivered to drug addicts,[5,6] and the active involvement of these groups is a central part of the planned response to the combined human immunodeficiency virus (HIV) and drugs problem.[7,8] Such a policy makes sense in view of the rapid growth in the range of drugs misused and the number of people misusing them,[9] the overload of services set up specifically for the drug misuser,[10] and the preference of drug misusers themselves for treatment by their general practitioner.[11]

The involvement of general practitioners and general psychiatrists in the care of drug misusers has been particularly actively pursued in the north western region of England where it received the active promotion of the regional medical officer and the backing of the regional psychiatric sub-committee. The work of general psychiatrists was at first supported by the development of satellite clinics in several health districts[12] which enabled district psychiatrists to obtain advice or a second opinion from a regional specialist. Subsequently, specialist, multidisciplinary community drug teams were developed in all 19 health districts in the region.[13] It was planned that these teams would provide advice to the general practitioners in their district and that the general practitioners would themselves offer the bulk of the treatment that drug misusers would need.[14,15]

The success of this policy depends on the willingness of general practitioners and general psychiatrists to take on a group of patients who are often assumed to be both difficult and refractory to treatment. It is important, therefore, to know how much general practitioners and general psychiatrists are prepared to do in practice, and how well they will respond to encouragement to play a more active part in the care of drug misusers. Data from an extensive evaluation of the north western region's drug services are reported here. They show how much care was provided by general practitioners and general psychiatrists, and how the situation changed over 15 months. The period chosen, from 1 January 1986 to 31 March 1987, coincided with the proliferation of community drug teams and district drug advisory committees throughout the region, and followed considerable national[3] and local[16] publicity about the important role of the general practitioner and general psychiatrist in services for drug misusers.

Method

Health districts studied

Three health districts were chosen for detailed study. The first was a seaside resort with a large annual influx of drug users; this had a medically oriented service with little contact with other drug services in the region. The second was a largely metropolitan area with areas of considerable deprivation; this district had one of the original satellite clinics and community drug teams. The third district was a mill town bordering Manchester; this district was developing a community drug team during the course of the study. The total population of these health districts was

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658 500, with 292 200 people between the ages of 15 years and 44 years. The total population of the area covered by the North Western Regional Health Authority was 3 990 000. All figures apply to the first year of the study.

Existing records

Information about cautions and arrests for drug-related offences and about seizures of illicit drugs was obtained from the annual reports of the chief constables of the Greater Manchester and Lancashire police forces. The number of notifications of drug misusers and information about persons involved in drug-related offences were taken from statistics published annually by the Home Office *(Statistical bulletin on the misuse of drugs).* Information about the number of methadone prescriptions issues in the region and the total amount of methadone dispensed was obtained from the Prescription Pricing Authority.

North western regional drug misuse database

A voluntary method for professionals to report drug misuse among patients was introduced in the north western region in 1985, as part of an evaluation of new district services for drug misusers.[17,18] A printed, selectively self-carboning form was designed with a top sheet which could be used in the patient's notes; a second sheet which could be used for Home Office notification of opiate or cocaine addiction; and a third sheet, which did not allow identification of the patient, for return to the regional database in a pre-paid envelope supplied with the form. The third sheet preserves the anonymity of individuals by using a code comprising initials, date of birth and sex, to avoid double counting. The first sheet enabled the following to be recorded: patient's name, address, telephone number, sex, date of birth, marital status, occupation and referral source, the identify and address of the reporting professional, and details of drug misuse (drugs and alcohol used and for each drug, source, frequency of use, amount used, route, duration of use, and age at first use). Doctors were requested to complete a form for each new patient or new episode of treatment of drug misuse.

The reporting method was described in *Manchester medicine,*[19] and actively publicized in the three health districts selected for study. Selected junior doctors, all general practitioners and all non-psychiatric consultants in these three health districts received five copies of the database form. Consultant psychiatrists received 10 copies. Supplies were also available through records departments and family practitioner committees.

The data presented here are from the total reports from the region, and the reports from the three study districts.

Interview study

Direct information about the treatment provided to drug misusers was obtained from two interviews with general practitioners, psychiatrists and probation officers in the three study districts. Probation officers were chosen because a local survey had identified the wide extent of drug misuse among their clients (unpublished results). All consultants in general psychiatry, a stratified sample of probation officers and a systematic sample of general practitioners were approached for interview. It was decided to exclude junior psychiatrists from the sample because their six month rotation would have made comparison between the two interviews less valid. Sub-specialists, such as psychiatrists who treated elderly people, who would be unlikely to see patients who misused drugs, were also excluded.

Although all eligible psychiatrists were contacted a substantial minority refused interview (Table 1). Probation officers were found to specialize in particular areas, for example some were day centre workers, some juvenile workers, and some had special responsibility for probationers and those on parole. Officers representing each specialty, with the exception of divorce work, were approached until at least 30% of the probation officers in each of the three districts had been contacted. General practices were contacted in the order that they appeared on an alphabetical list provided by the family practitioner committees until 60% of the practices in each health district had agreed to participate. One general practitioner from each practice was interviewed (the doctor was selected by the practice). The final sample amounted to a one in four sample of the general practitioners in the three health districts. The general practitioners completing both interviews were not significantly different from all general practitioners in the three health districts in respect of sex, whether in a single-handed or group practice, or list size. The general practitioners who refused interview did not differ significantly in their mean date of registration from those who were interviewed.

Table 1. Compliance with interview study.

	Number of:		
	General practitioners	Psychiatrists	Probation officers
Total in three districts	366	15	71
Approached	116	15	23
Refused first interview	15	3	0
Interviewed once	101	12	23
Refused or unavailable for second interview	11	3	5
Interviewed twice	90	9	18

The first interviews were undertaken in the first quarter of 1986. The second interviews were completed 12 months after the first.

The interviews were all conducted by A W using the same semi-structured format. The interviewees were asked to consider the misuse of opiates, stimulants, hallucinogens, cannabis, solvents, and cough linctus and were questioned about their perception of and knowledge about drug problems, their satisfaction with other services for drug dependence, and their practical response to drug misusers presenting to them.

Analysis

Data from the returned self-carboning form were entered into the database through *DBase*, after which the data were analysed with the statistical package for the social sciences (*SPSS.PC*). Statistical tests included a *t*-test, analysis of variance and the chi square test.

Results

There was a steady increase during the five year period up to and including 1986 in cautions and arrests for drug-related offences and in seizures of illicit drugs by the Greater Manchester and Lancashire constabularies, from 1121 and 1034, respectively, in 1982 to 1368 and 1678, respectively, in 1986. These statistics include cannabis-related offences, but this is not true of home office notifications which increased in the north western region from 421 new drug addicts in 1982 to 1339 in 1986. The number of methadone prescriptions issued in the region increased from 2500 in 1982 to 20 000 in 1986, and the total amount of methadone dispensed from 0.59 kg in 1982 to 2.48 kg in 1986. Between 1984 and 1985, coinciding with national publicity about the use of methadone in opiate detoxification, the number of methadone prescriptions increased from 3000 to 15 900. Before 1984, all methadone was prescribed as tablets or ampoules, but by 1986 63.6% of the 2.48 kg of methadone was prescribed as non-injectable liquid.

North western regional drug misuse database

To July 1988, 6026 reports of drug misuse were received by the north western regional drug misuse database from the region as a whole. Of these, 2127 reports concerning 1792 drug misusers bore a date falling in the 15-month study period (1 January 1986 to 31 March 1987). The mean age of the drug misusers reported during this period was 27.3 years, 68.8% were male, 73.0% were unemployed, 54.8% were single and 32.8% were from occupational class 3M. The the most frequently reported drug of misuse was heroin (63.5% of the 1792 individuals) followed by a benzodiazepine (9.5%). These were also the most commonly used drugs: 67.8% of the 1792 drug misusers had used heroin and 18.3% had used benzodiazepines in the last month.

Reports to the database from doctors in the region did not increase appreciably between the first quarter of 1986 and the first quarter of 1987 (41 versus 44), but the total number of reports, including non-medical reports, increased by 32.5% over this period, from 335 to 444.

In the three health districts which were the subject of particular study, the total number of reports in the first quarter of 1987 at 126 was 1.6% lower than the 128 reports in the first quarter of 1986, but the number of reports from general practitioners was 70.4% lower (eight versus 27). The number of reports by general psychiatrists was four in the first quarter of 1986 and seven in the first quarter of 1987 — a 75.0% increase.

General practitioners were responsible for reporting the majority of the 81 drug misusers reported to the regional database by generalists, that is, doctors not specializing in drug dependence (59, 72.8%) in the three study districts during the 15-month study period. Of the 81 drug misusers 60 (74.1%) were taking heroin; 38 (49.4%) of the 77 misusers for whom information was available were currently injecting (any drug).

Socioeconomic and drug misuse profiles of individuals reported to the database were similar to those of individuals reported by doctors throughout the region. They changed somewhat over the course of the study, but there were no consistent trends and there were no statistically significant differences between the first quarter of 1986 and the first quarter of 1987. However, the numbers involved were small.

Interview study

The interviews confirmed that general practitioners were attending (seeing) fewer, rather than more, drug misusers at the end of the study period than they had at the beginning.The mean numbers of drug misusers attended by general practitioners in the three months before the first interview and before the second interview were 0.9 and 0.6, respectively, for doctors in the mill town and 1.6 and 1.1, respectively, in the seaside resort. However, the general practitioners in the metropolitan area attended a mean of 1.9 drug misusers before the first interview and 2.5 before the second interview. The overall figures were a mean of 1.4 drug misusers attended by general practitioners in early 1986 and 1.2 in early 1987. This change was especially marked when heroin users were considered separately. The general practitioners at the first interview estimated that they had a total of 164 heroin misusers on their lists compared with 90 at the second interview (reduction of 45.1%).

The reduction in the mean number of drug misusers attended in the previous three months was also apparent from the interviews with psychiatrists from the three study districts — 5.1 before the first interview and 1.4 before the second. Probation officers' estimates of the number of clients with drug problems on their caseloads increased over the same period from a mean of 3.8 clients at the first interview to a mean of 4.3 at the second.

General practitioners at both interviews ranked assessment and referral as their highest priority, followed by dealing with the physical complications of drug misuse. Detoxification was given a low priority at both interviews although there was a non-significant tendency for general practitioners to rate detoxification as less important, and maintenance treatment as more important at the second interview compared with the first.

When general practitioners' actual treatment of opiate misusers was considered, it was found that there was no change between the two interviews in the proportion of drug misusers receiving a prescription for methadone (or similar opiate drug) (51/64 drug misusers, 79.7% versus 30/37, 81.1%). However, a significant change had occurred in the type of prescribing with general practitioners being less likely to prescribe according to a drug reduction regimen (of up to six months) and more likely to prescribe on an open-ended or maintenance basis (17/51 drug misusers, 33.3% versus 17/30, 56.7%; $\chi^2 = 4.2$, $P<0.05$).

There was a highly statistically significant increase in the percentage of drug misusers whom the general practitioner neither accepted for treatment nor referred (17/144, 11.8% versus 42/110, 38.2%; $\chi^2 = 24.3$, $P<0.001$). However, there was a fall in the percentage of psychiatrists' patients for whom nothing was done (26/61, 42.6% versus 2/11, 18.2%). The percentage of drug misusers referred to general psychiatrists by general practitioners dropped from 11.1% (16/144) to 2.7% (three/110) in the three districts. The percentage of drug misusers referred by general practitioners to all agencies (including the regional drug unit and the community drug teams) fell by a smaller amount (39/144, 27.1% versus 22/110, 20.0%).

Forty eight per cent of general practitioners and 75.0% of psychiatrists had received training in or attended talks on the treatment of drug dependence in the year before the first interview, but only 24.4% of general practitioners and no psychiatrists had done so in the succeeding year. At the first interview, 68.4% of 98 general practitioners and 81.8% of 11 psychiatrists said that they wanted their level of involvement to stay the same, or even to decrease; at the second interview the corresponding figures were 70.2% of 84 and 88.9% of nine, respectively. None of these differences between the first and second interview was statistically significant.

Discussion

Two strategies have been used to assess the contribution of general practitioners and psychiatrists to the care of drug misusers: returns to a database covering the whole of one health region, but concentrating on three selected health districts, and interviews with general practitioners and general psychiatrists in those health districts. Both methods have their flaws. The database is a voluntary reporting system, although overlapping with the Home Office notification procedure which is mandatory in the case of opiate and cocaine misusers. Returns to the database may not therefore reflect numbers of patients seen with complete accuracy. The interviews, although conducted using a semi-structured format, relied on the doctor's memory and, in the case of psychiatrists, 20% refused to participate. However, the fact that two, independent measures of activity have been used is likely to offset the introduction of any systematic bias into the data by these factors.

Health service statistics and reports to the database did not indicate that the rates of drug misuse fell in the north western health region during the study period. However, general practitioners reported fewer drug misusers to the regional database at the end of the study period than at the beginning. This was despite considerable publicity and encouragement to report to the database, and the provision of special forms which made report-

ing easy. This fall should be compared with the increase in the overall rate of reporting to the database, suggesting that the decrease cannot be attributed to a general trend in the prevalence of drug misuse, or in compliance with the database.

The interview study of psychiatrists and a sample of general practitioners in three health districts also disclosed an overall fall in the number of drug misusers attended by the doctors interviewed, and a fall in the number of heroin users on the general practitioners' lists. However, probation officers reported that their caseloads had increased over the same period suggesting that the fall for psychiatrists and general practitioners could not be attributed to a change in prevalence, or to the effect of being reinterviewed.

Had general practitioners and psychiatrists in the north western region, and in the three study districts in particular, responded to the national appeals to become the first line of care for drug misuse, a substantial increase in their activity in relation to drug misuse would have been expected during the course of a 15-month period in which there was considerable publicity about the new policy. Instead there was, if anything, a fall. The data presented here are most reliable for the three study districts, but they were chosen to be representative of the whole region, and there is no reason to suppose that the findings cannot be generalized to the whole region.

It is possible that general practitioners and psychiatrists were increasing their contribution to care over the study year by taking on more difficult or more seriously addicted individuals. However, as has been reported elsewhere, the profile of drug misuse of the patients seen by doctors over the study period did not change significantly.[18] In fact, general practitioners reported having 45% fewer heroin users on their lists at the end of the study than at the beginning, during a period when it was anticipated that their involvement would increase.

Fewer general practitioners and psychiatrists had received training in or attended talks on drug misuse in the year before the second interview than in the year before the first interview. There was also a tendency for general practitioners to make fewer referrals to psychiatrists. General practitioners offered no treatment or referral to significantly more of the drug-misusing patients whom they saw when compared with the previous year. These results may be associated with a diminution of general practitioners' and general psychiatrists' interest in drug misusers.

Although the findings are based on only one health region, it was one that actively prosecuted the national policy of making general practitioners and general psychiatrists the first line of care for drug misusers through both regional and district drug advisory committees. It therefore seems likely that, had the policy been having an effect, it would have been noticeable in the north west region. The fact that it did not suggests that the national policy may be having less impact than planned, indeed that it may be failing.

The active involvement of all general practitioners and general psychiatrists in the treatment of drug misuse is an essential component of the plans to reduce the speed and eventual penetration of HIV through the drug-misusing population (and through this potential 'bridge' group to the broader general population). The results of this study call into question the current view that such a change can be achieved sufficiently rapidly.

Concern has previously been expressed[20] that the policy makers may have underestimated the reluctance of general practitioners to take on the treatment of the opiate addict in a general practice setting — especially when this relates to the management of addicts in the long term without ready support from a specialist unit,[21] and the findings presented here provide substance for these concerns. The findings are also consistent with those of a small unpublished study conducted by the Department of Health and Social Security in late 1987 in which they found little evidence of activity in the treatment of drug dependence in the sample of general psychiatric outpatient clinics in 15 National Health Service hospitals across England studied over a three month period.

It is not being suggested that drug misusers are being neglected in the north west region. Other services were being developed during this period and continue to be influential, such as community drug teams, which appear to be taking over the provision of first line care from general practitioners.[22,23] The provision of a direct clinical service by these teams was not originally planned, and represents a response to demand by drug misusers unable to obtain help elsewhere, consistent with these findings of a reduction in the general practitioner's drug misuser caseload. It appears that the enthusiastic worker with substance abusers who is encouraged to adopt a facilitating or 'consultancy' role for the general practitioner or psychiatrist,[24] but is daily confronted with lack of enthusiasm or hostility from medical colleagues, eventually delivers a direct service, thus recreating the specialist service at a local level instead of achieving greater involvement of the generalist.

The success or failure of a planned response to the HIV/drugs problem will depend in large part on the extent to which the broad mass of generalists are willing to be actively involved as providers of a service that may include the prescribing of substitute drugs. The evidence of this study suggests that neither general practitioners nor general psychiatrists have accepted the burden of the medical care of the drug misuser.

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